MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (x) Yes ( ) No
Requestor's Name and Address. Memorial Hermann Hospital System c/o Sullins, Johnston, Rohrbach & Magers 3200 Southwest Freeway Houston, TX 77027	MDR Tracking No.: M4-04-3212-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address American Casualty Company c/o Burns, Anderson, Jury & Brenner Box 47	Date of Injury: Employer's Name: Dennys Corporation Insurance Carrier's No.: 3C801342

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
11/04/02	11/13/02	Inpatient Hospitalization	Actual cost plus 10%	$0.00

PART III: REQUESTOR'S POSITION SUMMARY

Position Summary states in part, "…The total charges for the implants provided by Memorial Hermann is $37,998.00. On October 30, 2003, we provided a copy of the actual cost of the implant invoices to RSKCO-CAN. Texas. Pursuant to the Texas Workers' Compensation Medical Fee Guidelines, Memorial Hermann is seeking reimbursement of its actual cost of the implants plus an additional 10%…"

PART IV: RESPONDENT'S POSITION SUMMARY

Position Summary states in part, "…Even if Provider had timely filed its request for dispute resolution for all of the dates of service in dispute, it would still not be entitled to an order for payment because it has already been paid at cost plus ten percent for implants billed under revenue code 278… Provider's bill was originally submitted to the Carrier without the implant invoices… As a result, Provider was reimbursed under the standard per diem reimbursement method. Under that method, Provider is entitled to reimbursement of $10,062.00 (9 x $118)…Provider subsequently re-submitted its bill with the implant invoices. Reimbursement was then recalculated under the stop-loss reimbursement method with provider being reimbursed at cost plus ten percent for the implants and 75% for the remaining billed charges. Under this method, Provider is entitled to reimbursement of $44,375.25… Pursuant to a PPO contract, the $44,375.25 amount was reduced by $2,515.50 to $41,859.75… The $10,062 already paid by the Carrier was then subtracted from this amount and Provider was issued additional payment of $31,797.75. Therefore, Provider has been reimbursed at cost plus ten percent for implantables and 75% of the remaining charges, less the PPO reduction…"

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

Per Rule 133.307(d) the disputed date of service 11/04/03 is considered untimely filed and cannot be considered in this review. The remaining dates of service 11/05/03 through 11/13/02 will be reviewed in accordance with Rule 134.401.

This dispute relates to inpatient services provided in hospital setting with reimbursement subject to the provisions of Rule 134.401 (Acute Care Inpatient Hospital Fee Guideline). The hospital has requested reimbursement according to the stop-loss method contained in that rule. Rule 134.401(c)(6) establishes that the stop-loss method is to be used for "unusually costly services." The explanation that follows this paragraph indicates that in order to determine if "unusually costly services" were provided, the admission must not only exceed $40,000 in total audited charges, but also involve "unusually extensive services."

After reviewing the documentation provided by both parties, it does **not** appear that this particular admission involved "unusually extensive services." Accordingly, the stop-loss method does not apply and the reimbursement is to be based on the per diem plus carve-out methodology described in the same rule.

The total length of stay for this admission was 9 days (consisting of 9 for surgical). Accordingly, the standard per diem amount due for this admission is equal to $10,062.00 (9 times $1,118). In addition, the hospital is entitled to additional reimbursement for (implantables/MRIs/CAT Scans/pharmaceuticals) as follows: The requestor submitted two invoices for implantables, the first in the amount of $5,994.35 and the second in the amount of $3,602.60; however, neither of these amounts correspond to the detailed list submitted by the Requestor; therefore, MDR cannot determine if the implantables listed on invoices submitted were used on date of service 11/05/03 as indicated on the detailed list. The requestor did not submit a copy of the operative report(s) that would confirm the date the implantables were utilized.

The Respondent states in their decision that they have reimbursed the Requestor a total of $41,859.75 ($10,062.00 + $31,797.75). The Table of Disputed Services submitted by the Requestor's representative does not list an amount in dispute; therefore, it is unclear what the actual amount in dispute is.

Based on the facts of this situation, the parties' positions, and the application of the provisions of Rule 134.401(c), we find that the health care provider is not entitled to any further reimbursement.

PART VI: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is **not** entitled to additional reimbursement.

Findings and Decision by:

	Marguerite Foster	March 21, 2005
Authorized Signature	Typed Name	Date of Decesion

PART VII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART VIII: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____